



## ***Texas Department of Insurance***

### ***Division of Workers' Comp***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

NISAL CORP  
P O BOX 24809  
HOUSTON TX 77229

#### **Respondent Name**

VANLINER INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 01

#### **MFDR Tracking Number**

M4-11-4405-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Please be advised that this patient was in a pre-authorized or Division exempted return –to-work rehabilitation program, therefore preauthorization for the repeat interview was not required."

**Amount in Dispute:** \$75.00

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "Vanliner Insurance Company's bill review and processing agent denied Nisal Corp's bills for the 11/02/2010 date of service because, 'precertification/preauthorization/notification absent. Preauthorization should have been obtained.' Nisal Corp did not obtain the requisite preauthorization for the disputed 11/02/2010 date of service as required in accordance with TDI Rule 134.600(p)(7)." "There is no existing documentation which proves that the claimant was participating in a preauthorized or exempt work conditioning/hardening or pain management program on the date (11/02/2010) of the 'Psych testing by technician' billed under CPT Code(s) 96102." "On 11/18/2010, Vanliner Insurance Company's delegated preauthorization agent, (Coventry) granted preauthorization for ten visits of pain management with a start date of '11/15/10' and an end date of '01/15/11'. A copy of this approval is attached hereto!" "In summation, Vanliner Insurance Company has appropriately denied payment for the disputed health care treatments/services billed by Nisal Corp."

**Response Submitted by:** Workers' Compensation & "CARF" Consultants, P. O. Box 92346, Austin, Texas 78709-2346

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2010	96102	\$75.00	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated May 11, 2011
  - 1 - 197 – Precertification/authorization/notification absent.
  - 1 – Pre authorization should have been obtained. (M768)

### **Issues**

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. Per Texas Labor Code, Section §413.011(b) “the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission.” 28 Texas Administrative Code, Section §134.600(p)(7) requires preauthorization of “all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program.” Review of the submitted documentation finds that the requestor obtained preauthorization approval under number 9085651 on November 18, 2010 for Pain management program 5x Week x 2 weeks with a start date of November 15, 2010 and an end date of January 15, 2011.
2. Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 Texas Administrative Code, Section §134.600. Therefore, no reimbursement is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	October 10, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**